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Note by the Secretary-General

The Secretary-General has the honour to transmit to the members of the General Assembly the report of the Joint Inspection Unit entitled "Review of the Medical Service in the United Nations system" (JIU/REP/2011/1).

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REVIEW OF THE MEDICAL SERVICE IN THE UNITED NATIONS SYSTEM

Prepared by

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Joint Inspection Unit

Geneva 2011

United Nations

JIU/REP/2011/1
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EXECUTIVE SUMMARY

Review of the medical service in the United Nations system
JIU/REP/2011/1

This system-wide review assesses the manner in which medical services are provided, managed, supported and monitored in the United Nations system, with a view to proposing improvements that will enable the United Nations to fulfil its duty of care with regard to the health and safety of staff. This is of particular importance when considered in the context of the United Nations strategic movement towards mobility and increased field presence, and of particular relevance to staff deployed at hardship duty stations.

The report considers the mandate of the United Nations Chief Medical Director and the Medical Services Division (MSD), as specified in ST/SGB/2004/8, and concludes that in the light of the recommendation of the High-Level Committee on Management (HLCM) on Occupational Safety and Health (OSH), the Secretary-General should modify the mandate/role of MSD. One key feature of OSH, and in particular of OSH medical services, is that such services should remain independent from other administrative/organizational units and report either directly to the Chief Executive Officer (CEO) or to his/her appointed representative. This implies that OSH medical services, while working in close collaboration with human resources, must not report to them directly.

The adoption of OSH policies by United Nations system organizations will necessitate a paradigm shift in the provision of medical services. It will also lead to cost-efficiencies. Emphasis will now be placed on prevention rather than cure. As stated by a former Secretary-General of the United Nations, "…staff are this Organization's greatest asset. We must treat them as such."

While describing the medical services and programmes provided at headquarters duty stations, the report focuses on medical services in the field, as the latter are deemed to be inadequate. It describes the functions of the respective service providers and their interaction with MSD, United Nations Medical Directors Working Group (UNMDWG) and United Nations Department of Safety and Security (UNDSS), and draws attention to the need to improve the overall coordination of system-wide medical services. The issue of accountability in field medical services is raised; for although MSD is supposed to be the "technical supervisor", it actually has no input with regard to the budgets and work plans of field units, nor in the performance management process of the other service providers. Furthermore, United Nations dispensaries are now "managed" by the respective Resident Representatives and/or Country Teams on the basis of a draft Terms of Reference prepared by United Nations Development Programme (UNDP). This decentralization has led to accountability issues and difficulties in overcoming disagreements on cost-sharing by the various agencies using the facilities.

An overview of the existing system-wide and inter-agency bodies that coordinate and/or cooperate on medical and OSH issues is presented. With a view to facilitating the implementation of OSH policies and enhancing coordination, the report concludes with a call for the establishment of a system-wide network for OSH issues (including, but not limited to, medical services), modelled on the Inter-Agency Security Management Network (IASMN) that addresses security issues. The proposed new coordinating body would monitor the implementation of United Nations OSH policies, practices and procedures, and thereby support HLCM in its comprehensive review of issues pertaining to the entire United Nations occupational safety and health structure.

The United Nations has invested considerable resources in employing a large number of health-care personnel across the system, but has not yet created the structures required to oversee and manage these resources according to modern health-care standards.

The review contains seven recommendations, of which the following two are addressed to legislative bodies.

Recommendation 2

The legislative bodies of United Nations system organizations should adopt appropriate standards with regard to Occupational Safety and Health issues, taking into account and ensuring compatibility with emerging modifications to the Minimum Operating Safety and Security Standards.

Recommendation 7

The General Assembly should mandate the Secretary-General to create the United Nations Network on Occupational Safety and Health, with a defined Terms of Reference, and which should be headed by the United Nations Chief Medical Director.

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ABBREVIATIONS

ACABQ	Advisory Committee on Administrative and Budgetary Questions
ACC	Administrative Committee on Coordination
CEB	United Nations System Chief Executives Board for Coordination
CEO	Chief Executive Officer
COE	Contingent Owned Equipment
CISMU	Critical Incident Stress Management Unit
CISWG	Critical Incident Stress Working Group
CTBTO	Comprehensive Test Ban Treaty Organization
DFS	Department of Field Support
DPA	Department of Political Affairs
DPKO	Department of Peacekeeping Operations
EAP	Employee Assistance Programme
ECA	Economic Commission for Africa
ECE	Economic Commission for Europe
ECLAC	Economic Commission for Latin America and the Caribbean
ERP	Enterprise Resource Planning
ESCAP	Economic and Social Commission for Asia and the Pacific
ESCWA	Economic and Social Commission for Western Asia
FAO	Food and Agriculture Organization of the United Nations
FMT	Forward Medical Teams
HLCM	High-Level Committee on Management of the CEB
HRN	Human Resources Network
IAEA	International Atomic Energy Agency
IASMN	Inter-Agency Security Management Network
ICAO	International Civil Aviation Organization
ILO	International Labour Organization
IMO	International Maritime Organization
INFM	Inter-Agency Network for Facilities Management
IOM	International Organization for Migration
ITC	International Trade Centre
ICTR	International Criminal Tribunal for Rwanda
ITU	International Telecommunication Union
JIU	Joint Inspection Unit of the United Nations system
LOA	Letter of Agreement
LSD	Logistics Support Division
MOSS	Minimum Operating Safety and Security Standards
MOU	Memorandum of Understanding
MSD	Medical Services Division
MSS	Medical Support Section
MSU	Medical Support Unit
OIOS	United Nations Office of Internal Oversight Services
OPCW	Organization for the Prohibition of Chemical Weapons
OPS	Office of Planning and Support
OSH	Occupational Safety and Health
PCC	Police Contributing Countries
PHTLS	Pre-Hospital Trauma and Life Support

SSS	Specialist Support Section
TCC	Troop Contributing Countries
TOR	Terms of Reference
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UNDSS	United Nations Department of Safety and Security
UNEP	United Nations Environment Programme
UNEPs	United Nations Examining Physicians
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UN-HABITAT	United Nations Human Settlements Programme
UNHCR	Office of the United Nations High Commissioner for Refugees
UNHQ	United Nations Headquarters
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNMDWG	United Nations Medical Directors Working Group
UNMIL	United Nations Mission in Liberia
UNNOSH	United Nations Network on Occupational Safety and Health
UNODC	United Nations Office on Drugs and Crime
UNOG	United Nations Office at Geneva
UNON	United Nations Office at Nairobi
UNOV	United Nations Office at Vienna
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
UNSECOORD	United Nations Security Coordinator
UNSIC	United Nations System Influenza Coordination
UNSSCG	United Nations Staff/Stress Counsellors Special Interest Group
UNV	United Nations Volunteers
UNWTO	World Tourism Organization of the United Nations
UPU	Universal Postal Union
VIC	Vienna International Centre
WFP	World Food Programme
WHO	World Health Organization
WIPO	World Intellectual Property Organization
WMO	World Meteorological Organization

I. INTRODUCTION

1. As part of its programme of work for 2010, the Joint Inspection Unit (JIU) conducted, from February to November 2010, a "Review of the medical service in the United Nations system", based on proposals submitted by the Office of Human Resources Management - Medical Services Division (MSD) and the Office of Internal Oversight Services (OIOS).

2. This system-wide review assesses the manner in which medical services in the United Nations system are provided, managed, supported and monitored, with a view to proposing improvements that will enable the United Nations to fulfil its duty of care with regard to the health and safety of staff. This is of particular importance when considered in the context of the United Nations strategic movement towards mobility and increased field presence, and of particular relevance to staff deployed at hardship duty stations. As stated by a former Secretary-General of the United Nations, "…staff are this Organization's greatest asset. We must treat them as such."[1]

3. The scope of the report does not include medical insurance issues, as they have been dealt with in a previous JIU report,[2] nor does it address the quality of care (medical treatment) provided by United Nations medical staff. It also does not delve into the subject of sick-leave management, as this will most likely be the topic of a forthcoming JIU review, as has been requested by a number of United Nations system organizations.

4. The report will further elaborate on the implications of the endorsement by the High-Level Committee on Management (HLCM) of the Chief Executives Board for Coordination (CEB) of the proposal submitted by the United Nations Medical Directors Working Group (UNMDWG) for the adoption of an Occupational Safety and Health (OSH) policy[3] and its recommendation that all organizations adopt an individual OSH policy.[4]

5. The adoption of OSH policies by United Nations system organizations will necessitate a paradigm shift in the provision of medical services, as emphasis will now be placed on prevention rather than cure[5]. Chapter II describes what this shift entails, while chapter III provides background information on the medical services currently provided at both headquarter and field duty stations, taking into account the fact that future organizational/managerial change somewhat limits the analysis of current practices.

6. Chapter IV of the report provides an overview of the system-wide bodies that currently either cooperate on or coordinate health issues. Finally, chapter V calls for the establishment of a system-wide mechanism to monitor and manage OSH.

Methodology

7. In accordance with JIU internal standards and guidelines, the methodology followed in preparing this report included a detailed desk review, questionnaires, interviews and an in-depth analysis.

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[1] See http://www.un.org/News/Press/docs/2006/sgsm10705.

[2] United Nations system staff medical coverage (JIU/REP/2007/2).

[3] Occupational Health and Safety Policy in the UN System, Submission of the UN Medical Directors Working Group, CEB/2010/HLCM/11, 11 February 2010.

[4] Healthcare and its management in the United Nations system, CEB/2009/HLCM/32.

[5] CEB/2010/3, para 77.

8. The Inspector conducted interviews in person and by tele/videoconference, as well as on-site visits to United Nations medical facilities in order to obtain the views of many medical service staff, as well as officials in human resources and finance departments within the United Nations system organizations and in various duty stations, as well as UNMDWG member organizations. The Inspector also visited Department of Peacekeeping Operations (DPKO) medical facilities in Lebanon and Liberia. Close collaboration was maintained between the Inspector and members of the UNMDWG steering committee at various stages of the review.

9. The Inspector was invited to present his preliminary findings, based on the responses received to his questionnaires, at the UNMDWG annual meeting, hosted by the International Labour Organization (ILO) in Geneva, Switzerland, in October 2010. After the presentation, the participants discussed at length the emerging findings and possible recommendations.

10. Comments on the draft report were sought from all the United Nations system organizations and UNMDWG members who responded to the questionnaires, and taken into account in finalizing the report.

11. In accordance with article 11.2 of the JIU statute, this report was finalized after consultation among the Inspectors aimed at testing its conclusions and recommendations against the collective wisdom of the Unit.

12. To facilitate the handling of the report, implementation of its recommendations and monitoring thereof, annex V contains a table indicating whether the report has been submitted to the organizations concerned for action or for information. The table identifies the recommendations relevant to each organization, and specifies whether they require a decision by the organization's legislative or governing body, or whether they can be acted upon by the organization's executive head.

13. The Inspector wishes to express his appreciation to all those who assisted him in the preparation of this report, in particular the persons who participated in the interviews, provided responses to the questionnaires, and so willingly shared their knowledge and expertise.

II. OCCUPATIONAL SAFETY AND HEALTH

14. The ILO Occupational Health Services Convention (No. 161) defines "occupational health services" as services entrusted with essentially preventive functions and responsible for advising the employer, the workers and their representatives in the undertaking on the requirements for establishing and maintaining a safe and healthy working environment which will facilitate optimal physical and mental health in relation to work; and the adaptation of work to the capabilities of workers in the light of their state of physical and mental health (article 1).

15. The manner in which such health services are provided is usually stated in the organization's occupational safety and health (OSH) policy, prepared by the CEO of the organization. A written policy provides the framework within which an effective OSH programme can be implemented. An OSH policy statement should concisely define the mandate, and allocate specific resources to health and safety activities. The policy should be updated regularly.

16. The implementation of an OSH policy is usually codified in a manual (administrative instruction). While the content and structure may vary between organizations, there are certain common features, as specified below.

17. Responsibility and accountability: OSH is a responsibility which starts at the highest organizational level and is passed down the line management chain to all supervisors. Employees have a duty to follow the health and safety rules of the organization, and to participate in the implementation of OSH policies and activities. It should be noted that it is **not** the medical service or the OSH service that is responsible for staff health and safety. Rather those services and other dedicated OSH staff assist management in fulfilling its responsibility and duty of care concerning staff health and safety.

18. Risk management: This is a process in which hazards in the workplace are identified and analyzed in terms of the risk they pose, and risk elimination or mitigation strategies are developed and implemented. While effective emergency response is an important element of risk management to reduce the impact of work-related injuries, ill health, diseases and accidents, it should always be preceded by efforts to prevent such incidents from occurring in the first place.

19. OSH oversight body: Effective implementation of an organizations' OSH policy is best achieved through the appointment of a representative group of staff with a clear mandate and documented responsibilities in the form of an OSH committee. This committee should comprise, at the minimum, staff representatives, representatives of the OSH medical and counselling services, representatives from human resources, representatives from facilities and services management, representatives of the health insurance office, and security services.

Senior management commitment to OSH would be reflected through this committee being chaired and supervised by the Deputy CEO or his/her representative.

20. Training: A successful OSH programme presupposes that managers and employees, in particular the members of the OSH committee, are trained (and on a continuous basis) in order to understand their roles, responsibilities and expected actions, so as to achieve OSH goals.

21. All staff must be made aware of potential risks in the work environment, and the measures adopted to minimize such risks. More importantly, they must be familiar with the OSH services available to them,

including what they do, and do not, provide. The expected outcomes of the components of such services are listed in Table 1 below. The extent to which such OSH services are provided is relative to each organization's risk profile.

Table 1
Representative components and outputs of an Organizational Safety and Health programme[6]

Leadership/management

- Organizational commitment;
- Innovation and change management;
- Health information systems;
- Programme evaluation and quality improvement;
- Privacy, medical confidentiality and health records management systems;
- Systematic research, statistics and epidemiology.

Healthy workers

- Health evaluation of workers (pre-assignment/pre-placement, medical monitoring, post-illness or injury, fitness-for-duty evaluation, independent medical examinations);
- Occupational injury and illness management;
- Non-occupational injury and illness management (depending on local health care infrastructure);
- Travellers health and infection control;
- Mental and behavioural health/misuse of substances;
- Medical screening and preventive services.

Health environment

- Workplace health hazard evaluations, inspection and abatement;
- Education regarding environmental hazards;
- Personal protective equipment (when exposure cannot be avoided);
- Toxicology assessments;
- Environmental protection programmes;
- Emergency preparedness, business continuity planning and disruption prevention;
- Healthy organization (health promotion programmes);
- Health benefits management;
- Integrated health and productivity management.

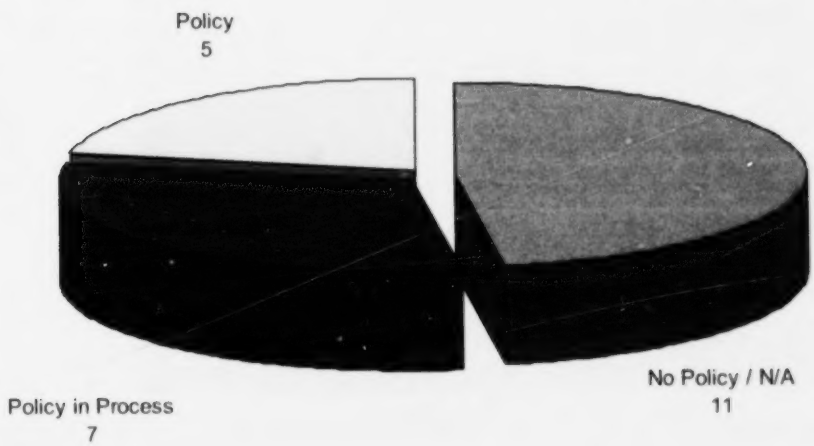
[6] Occupational Health and Safety Policy in the UN System, Submission of the UN Medical Directors Working Group, annex 1, CEB/2010/HLCM/11, 11 February 2010.

OSH implementation

22. While a few organizations have adopted an OSH policy (see Figure 1 below), the Inspector wishes to cite the Food and Agriculture Organization of the United Nations (FAO) and the Organization for the Prohibition of Chemical Weapons (OPCW) as organizations that have implemented the OSH core elements stated above.[7] The ILO's OSH announcement, on the other hand, does not specify that it is the Director-General who is responsible, rather responsibility is vested in the Office of the Director-General; nor are resources specifically allocated for OSH, instead, they fall "within the provisions of the programme and budget."[8] The World Health Organization (WHO) has recently adopted an OSH policy, which in the Inspector's view, incorporates key aspects of the core elements. However, the Director-General does not specifically assume responsibility, rather it is staff with managerial and supervisory responsibilities that do so.[9]

23. Be that as it may, the Inspector notes that many organizations/entities are in the process of adopting OSH policies, by designating focal points to drive the process. In that respect, some have already restructured their medical services to provide occupational health services for their staff at headquarters, and in some field presences. Thus there is precedence and best practice for other organizations to follow.

Figure 1
Number of organizations/entities with an OSH policy statement (as of March 2011)

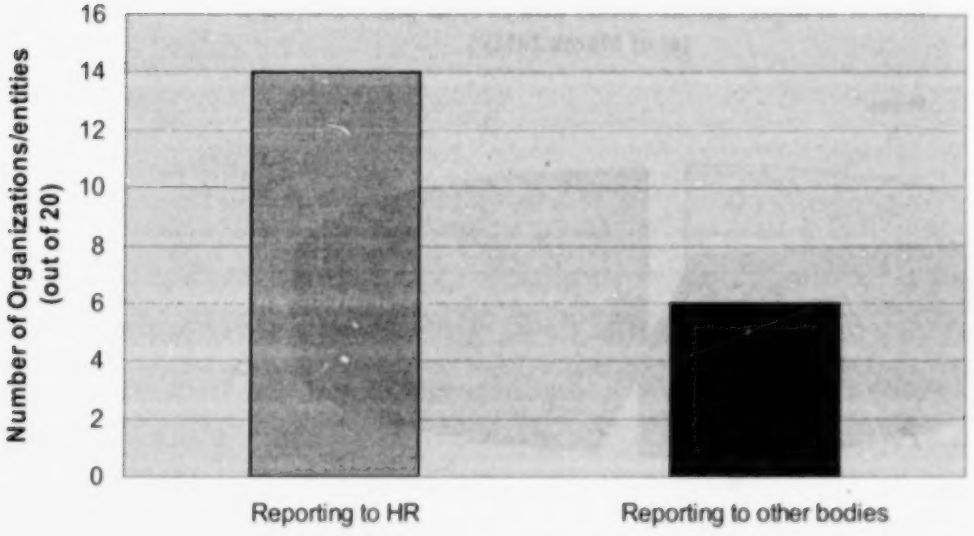


Note: Policy: FAO, IMO, OPCW, WHO, World Bank.
Policy in Process: ESCWA, ILO, IOM, UNESCO, UNHCR, UNHQ, UNWTO.
No Policy: ECA, ECLAC, ESCAP, IAEA, ICAO, ICTR, UNOG, UNON, UNRWA, UPU, WFP.
Source: Organizations' response to the Inspector's questionnaire.

[7] FAO Occupational Safety and Health Policy (to be published in 2011); OPCW Health and Safety Policy; OPCW Health and Safety Regulations, dated 14 May 1997 (C-1/DEC.8).
[8] ILO, Director-General's announcement, IODS number 48 (version 1), 11 November 2008.
[9] WHO, Occupational Safety and Health policy, para 8.

24. One key feature of OSH, and in particular of OSH medical services, is that such services should remain independent from other administrative/organizational units, and report either directly to the CEO or to his/her appointed representative, within the office of the CEO. This implies that OSH medical services, while working in close collaboration with human resources, must not report to them directly. This is the case already in some organizations (see Figure 2 for a breakdown), where medical services report to the Head of Administration or the Executive Office. While reporting lines can demonstrate independence from administrative/organizational units, it is better defined contractually and through a formal, legal basis. From a historical perspective, it should be noted that the United Nations Medical Service in New York was under the Executive Office of the Secretary-General (see SGB 97/Rev.1 (1 January 1955) and 97/Amend.2 (6 October 1955), and the Health Service was designated as an "independent service reporting to the Secretary-General through the Executive Office". Responsibility for the Medical Service was transferred to the Office of Human Resources Management in 1959 to meet a temporary situation, and still remains there today.[10]

Figure 2
Medical service reporting chain in the organization/entity (at headquarters) (as of June 2010)



Note: Reporting to HR: ESCAP, ESCWA, IAEA, ICAO, ILO, IMO, UNHQ, UNESCO, UNHCR, UNOG, UNON, WFP, WHO, World Bank.
Reporting to other bodies: ECA, ECLAC, FAO, ICTR, IOM, OPCW.
Source: Organizations' reponse to the Inspector's questionnaire.

25. A successful OSH policy would also lead to cost-efficiencies. For example, most of the medical expenses of OPCW Health and Safety Branch are related to external referrals for medical examinations, pathology (blood) testing or radiology. Each of these activities is being progressively implemented, subject to an "evidence-based" review. Well-established statistical proofs are used as the benchmark for adding to, removing

[10] Internal Memorandum to Joseph E. Connor, Under-Secretary-General, Department of Administration and Management, from Ingrid Laux, Director, Medical and Employment Assistance Division, Office of Human Resources Management, 4 March 1996.

or changing aspects of each activity. To date, this has led to a 26 per cent reduction in pathology costs, and a 90 per cent reduction in radiology costs. Revised clinical examination guidelines to be put in place in 2011 are expected to result in a 30 per cent decrease in overall pre-employment medical costs.[11] As well as monetary savings, this approach also saves significant staff time, which can then be directed towards newer strategies which have been shown to yield positive results, such as active case management and enhanced early return-to-work programmes. Over time, indirect savings, such as reduced sick leave and disability rates, are generated, which in turn give rise to significant benefits in the longer term, including financial savings, and removing or changing aspects of each activity.

26. Implementation of the recommendations below would enhance efficiency.

Recommendation 1

Executive heads of United Nations system organizations should appoint focal points in their respective organizations to facilitate the development and implementation of the necessary Occupational Safety and Health policies and procedures, and should present them without delay to their respective legislative bodies for adoption.

Recommendation 2

The legislative bodies of United Nations system organizations should adopt appropriate standards with regard to Occupational Safety and Health issues, taking into account and ensuring compatibility with emerging modifications to the Minimum Operating Safety and Security Standards.

[11] Source: OPCW Health and Safety Branch.

III. MEDICAL SERVICES IN THE UNITED NATIONS SYSTEM

27. The Director of the Medical Services Division (MSD) coordinates the system-wide implementation of United Nations medical standards and health policies, addresses health-care issues arising from all duty stations, and ensures staff access to benefit programmes. The Director is accountable to the Assistant Secretary-General for Human Resources Management. He/she acts as medical adviser on matters pertaining to the Advisory Board on Compensation Claims and is the designated medical consultant for the United Nations Joint Staff Pension Fund.[12]

28. The core functions of MSD include:[13]

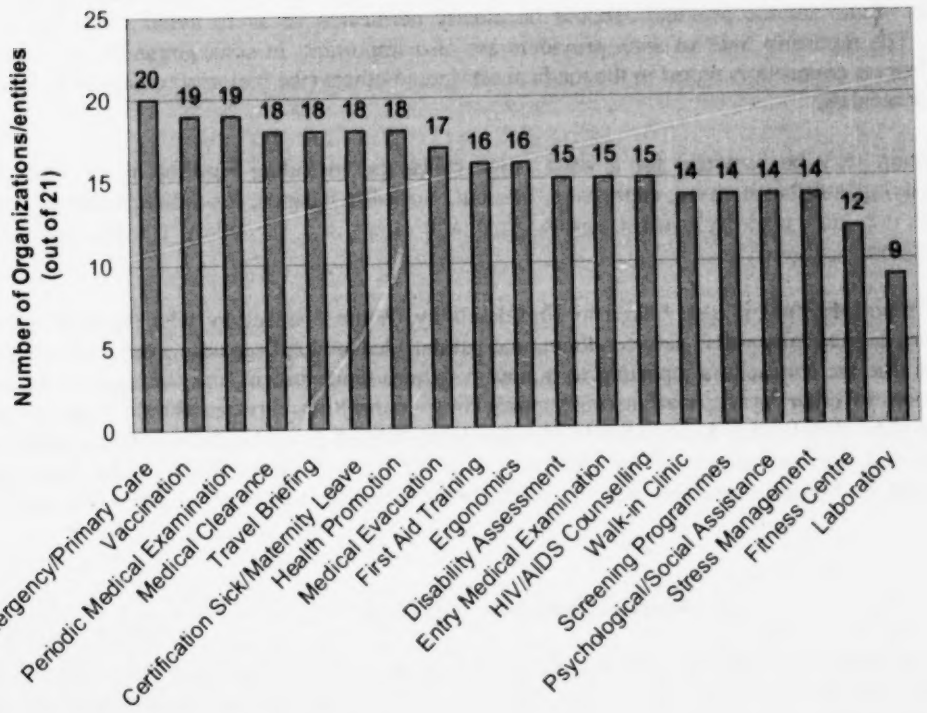
- To provide for the physical and mental health of staff worldwide and advise administration on staff benefits;
- To formulate and review United Nations medical standards, policies and guidelines, and ensure coordination and monitoring of system-wide implementation;
- To establish, update and coordinate United Nations system health advisories, including travel precautions, pre- and post-travel examinations, consultations, vaccinations, health education materials and travel kits;
- To promote a healthy, safe and compassionate work environment through health policies and guidelines, health promotion programmes, comprehensive medical emergency preparedness plans, and coordinate system-wide implementation of medical policies for HIV/AIDS;
- To provide medical clearance for recruitment, reassignment and mission deployment of staff worldwide, military observers and civilian police monitors;
- To evaluate and certify sick leave for staff worldwide;
- To determine the health rating of all duty stations reviewed by the International Civil Service Commission;
- To provide psychological assistance in the context of mission assignments, substance abuse and emergency preparedness;
- To advise on service-incurred injury and illness benefits for staff, and PKO military observers, police and contingents;
- To provide courtesy medical services to the staff of all permanent missions and observer missions to the United Nations, and to visitors and contractors;
- To provide health services to all New York-based staff of the United Nations system, including:

    - Medical examinations and consultations;
    - Travel health clinic;
    - Walk-in clinic;
    - Emergency and first-aid care;
    - Referral to outside specialists or hospitals;
    - Planning, organizing and implementing on-site health improvement programmes.

While the above describes the services provided by MSD, Figure 3 below indicates the medical/occupational health services provided by organizations/entities at their respective headquarters.[14]

[12] Secretary-General's bulletin, Organization of the Office of Human Resources Management (ST/SGB/2004/8), paras. 7.1, 7.2 and 7.3.
[13] Ibid., para. 7.5.
[14] See annex I for a detailed list of services provided at individual headquarters duty stations.

Figure 3
Main medical services and programmes provided at headquarters duty stations (as of June 2010)



Source: Organizations' réponse to the Inspector's questionnaire.

29. Some duty stations have established in-house laboratories, because they have determined that their presence on-site lowers costs (when compared with external providers) and is convenient for staff. Staff convenience and well-being were also reasons for establishing fitness centres, which is indicative of management initiative and support. The Inspector wishes to highlight certain additional services that are provided at some headquarters duty stations, at little or no extra cost to the organization/entity, which may be replicated at other locations. These services are indicative of an organization/entity's desire to provide a convenient means to improve the general well-being of staff. For example, FAO has a private medical clinic on the premises, which has a general practitioner and a physiotherapist. In Vienna, staff can schedule appointments with a private gynaecologist who runs a weekly clinic in the Vienna International Centre (VIC). The VIC also houses a pharmacy, which enables staff to fill prescriptions without leaving the building. Some organizations also provide self-measurement blood pressure machines. Finally, the World Bank has a dedicated website for health promotion, and organizes regular information sessions on various health-related topics.[15]

30. Most of the organizations surveyed also offer assistance to their staff to deal with their work-related or personal problems that may adversely affect their work performance, health and general well-being. Such

[15] For further information on measures adopted by United Nations system organizations with regard to work-life balance, see JIU report on Inter-agency Staff Mobility and Work/Life Balance in the Organizations of the United Nations System (JIU/REP/2010/8).

assistance is usually provided "in-house", either through staff welfare officers, staff counsellors, stress counsellors, ombudsmen, ethics officers, and others addressing staff relations, or a combination of the above. Such assistance may also be concurrently outsourced to external providers, as is the case of the Employee Assistance Program (EAP) at the International Civil Aviation Organization (ICAO). In that respect, the role and service description of the service providers should be clearly delineated so as to avoid confusion and/or misunderstanding. The reporting lines of such providers are also important; in some organizations (UNHQ, WHO, FAO), staff/stress counsellors report to the medical service, in others (the majority) counsellors report to human resources or security.

31. Assistance/support may be provided for a wide range of issues, including conflict in the workplace, harassment and bullying, substance abuse, depression, burnout, work-life balance, loneliness/isolation, marital and family issues, pre- and post-deployment issues, traumatic stress and secondary trauma, and human resources-related issues.

32. The matter of reporting lines is also linked to confidentiality. While counsellors who report to medical services have clearly defined "firewalls" between them, and patient files are kept separate from each other, and the same may hold true for counsellors reporting to human resources/management, the paramount concern is that of independence. In other words, staff members providing counselling services should function in an environment where their professional independence is guaranteed, thereby enabling them to better serve their client base. To this end, the Inspector is of the view that such service providers should not be reporting to medical services, nor to human resources, nor to security, but rather to the head of the OSH unit (see chapter II).

A. Medical directors – post levels

33. While the post of Director of MSD is graded as D-2, those of other medical directors are not at a similar grade (see Table 2 below). The Inspector is of the view that the posts of United Nations system health-care staff should be consistently graded system-wide, so as to accurately reflect the responsibilities that are shouldered on a daily basis, both in the field and at headquarters. In fact, some medical chiefs have expressed dissatisfaction regarding the grade discrepancies between duty stations of posts with similar levels of responsibility, especially as some of them are not only in charge of their own organization, but of others as well.

Table 2
Medical chiefs (headquarters) – post levels
(as of June 2010)

Organizations/entities	Grade
UNHQ	**D2**
FAO	D1
UNHCR	**D1**
WHO	D1
IAEA	**D1**
UNOG	P5
UNON	**P5**
ILO	P5
UNESCO	**P5**
UNRWA	P5
WFP (under FAO)	**P5**
ECA	P5
ECLAC	**P4**
ESCAP	P4
ESCWA	**P4**
ICTR	P4
ICAO[1]	**N/A**
IMO[2]	N/A
World Bank	**equivalent to D2**
OPCW	D1
IOM	**P4**

[1] Medical Chief is a consultant.

[2] Medical Chief is an advisor.

Source: Organizations' response to the Inspector's questionnaire.

34. For example, the medical chief posts at UNOG and UNON should be upgraded to that of Director, as they not only have inherent decision-making powers and are functionally independent from MSD, but are also responsible for services provided to many international organizations (headquarters) in Geneva and in Nairobi on a cost-sharing basis. The Inspector is also of the view that the medical chief posts in the regional commissions (ESCAP, ESCWA and ECLAC) should be reclassified to a senior managerial level, and the posts that are currently financed through extra-budgetary funds, should be converted to regular budget posts, pending reclassification.

B. Staff members' medical records

35. Given the emphasis today on staff mobility and increased field presence within the United Nations system, as well as from an administrative point of view, staff members' medical records should be easily accessible and transferable between duty stations. Apart from the ready availability offered, storage of medical records in electronic format would also meet current business-continuity and disaster-recovery requirements.[16] Table 3 below indicates the number of organizations/entities that have implemented this practice.

[16] See A/RES/63/269, 7 May 2009.

Table 3
Availability of staff members' medical records in electronic format
(as of June 2010)

	Organizations/entities	TOTAL
Yes	ECLAC, FAO, UNHQ, UNOG, WFP, WHO World Bank	7
No	ECA, ESCAP, ESCWA, IAEA, ICAO, ICTR, ILO, IMO, IOM, OPCW, UNESCO, UNHCR, UNON, UNRWA, UNWTO, UPU	16

Source: Organizations' response to the Inspector's questionnaire.

36. The Inspector notes that organizations/entities have adopted different programs for electronic filing of medical records, including EarthMed at United Nations headquarters, CHIMED/Préventiel at WHO, and Jasmine Web at UNOG. While it would seem optimal to adopt one program across the board, an organization's choice of electronic records platform should be respected. However, such platforms should, to the extent possible, enable system-wide compatibility. They should also be able to interface with Enterprise Resource Planning (ERP) systems, while ensuring the protection of confidential medical information.

37. The implementation of the recommendation below would facilitate the dissemination of best practices.

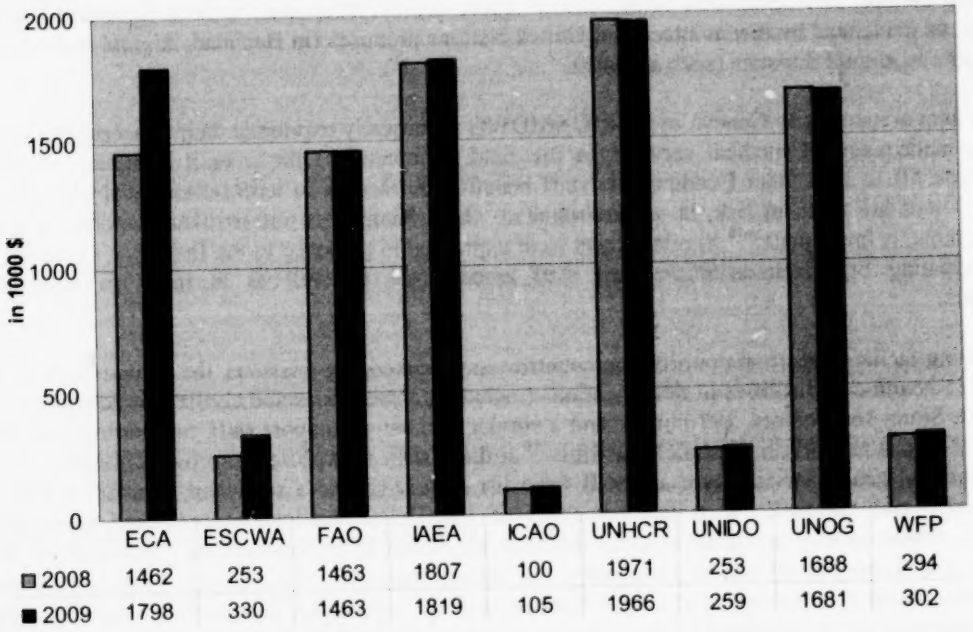
Recommendation 3

Executive heads of United Nations system organizations should implement systems enabling the electronic capture/archiving of staff members' medical records, if they are not already in place.

C. Financing of medical services

38. The Inspector notes from the responses to his questionnaire that, in general, resources at headquarters duty stations are sufficient for providing adequate medical services. All the organizations/entities have either maintained or increased their budgetary resources (regular, extra-budgetary or insurance participation) for that purpose. Figure 4 below lists some organizations/entities and the resources allocated for medical services.

Figure 4
Medical service budget at selected organizations/entities (headquarters) 2008-2009



Source: Organizations' reponse to the Inspector's questionnaire.

39. Nevertheless, some organizations/entities (such as ECA, ECLAC, ESCAP, IAEA, ILO, MSD, UNICEF, UNHCR, WFP and WHO) stated in their responses to the Inspector's questionnaire that there were insufficient resources to, for example:

- Hire additional medical service staff, including staff counsellors, to improve service delivery;
- Deliver training to medical service personnel;
- Support health promotion programmes at headquarters and field locations;
- Introduce a database and perform statistical analysis of work being done;
- Respond to emergency situations in the context of a national pandemic;
- Establish a satellite clinic in the Somali region;
- Provide mobile clinics in other regions (from Addis Ababa).

40. The quantum of financing for medical services provided by dispensaries could not be included as UNDP did not respond to the Inspector's questionnaire, and MSD does not have access to such information. Nevertheless, as each dispensary is financed on a cost-sharing basis, there is collective responsibility on all the organizations whose staff use the facilities. The prevalent use of United Nations volunteers (see figures 6 and 7) is perhaps indicative of the desire to minimize costs related to medical/OSH service provision.

D. Medical services in the field

41. United Nations staff are increasingly deployed to field duty stations, including to many areas with sub-optimal medical and health-care infrastructure. These deployments come with an increased risk to health and safety, as evidenced by recent attacks on United Nations premises (in Baghdad, Algiers and Afghanistan), and exposure to natural disasters (such as Haiti).[17]

42. At its annual meeting in Geneva in 2010, UNMDWG specifically expressed their concerns to the Inspector about the inadequacy of medical services in the field, compared to the overall adequacy of services at headquarters: "It is a fact that Headquarters staff benefit from access to world-class local medical services, while field staff are often at risk, in an environment where health-care infrastructure, including that of the United Nations, is inadequate."[18] Similar views were expressed in response to the Inspector's questionnaire by JIU participating organizations/entities and staff associations, as well as in meetings with concerned stakeholders.

43. Excluding facilities of troop-contributing countries in peacekeeping missions, the United Nations currently operates 121 health-care facilities in field locations (including dispensaries and civilian clinics in peacekeeping operations). Some 166 doctors, 197 nurses, and a similar number of support staff, are currently employed by the United Nations to work in these field facilities.[19] A dispensary is expected to provide primary clinical care and occupational health services (see annex II for a list of services) to a sufficient number (at least 200) of internationally and nationally recruited personnel of the United Nations system, and their recognized dependants, where locally available medical facilities are found to be inadequate.[20] However, if the health conditions in a country constitute an emergency, the United Nations Medical Director can, after consultation with the other Medical Directors in the United Nations system, recommend the establishment of a dispensary.[21] This recommendation is submitted to the relevant Resident Coordinator/Resident Representative who then forwards the proposal to the United Nations agencies concerned to obtain their agreement.

44. While MSD provides support to these facilities, by way of technical oversight of the medical staff, their daily administration/management is usually under the responsibility of the Country Teams, and individual overall accountability falls under either the Resident Coordinator or Special Representative of the Secretary-General. Hence, as a matter of urgency, the management and accountability framework for supporting United Nations clinics and dispensaries in the field should be clarified and promulgated in a defined Terms of Reference (TOR), taking into account the inter-agency common services that they are required to deliver. The Inspector was informed that, to date, such clinics are established/managed according to a draft UNDP TOR.[22] Challenges faced in resourcing United Nations field medical facilities, particularly United Nations dispensaries, should be addressed with dispatch, considering the services that they are expected to deliver in difficult, and often isolated, circumstances. These conditions should be taken into account when finalizing the above-mentioned TOR.

45. The Department of Field Support (DFS) drew the Inspector's attention to the challenges it faces in making its medical facilities accessible to other United Nations entities in the field. DFS medical facilities are deployed based on specific budgetary guidelines and operational needs, without necessarily considering the requirements

[17] A/65/305, 2 September 2010, para 140.
[18] Consolidated response to JIU presentation at UNMDWG annual meeting, October 2010.
[19] A/65/305, 2 September 2010, para 141.
[20] UN Dispensaries Draft, UNDP Office of Human Resources Bureau of Management, 2009.
[21] Ibid., para 11 (b).
[22] Refer to Guideline for Provision of Field Health Services.

of other United Nations entities that deploy in the field with negligible medical resources. Considering the prolonged negotiation periods for the finalization of local memorandums of understanding (MOUs) for such services in the field, due in part to difficulties defining reimbursement terms and in harmonizing budget lines, headquarters offices of some of these agencies are working with DFS to develop an umbrella MOU for sharing common services in the field. DFS can easily take the lead as far as the medical component of this MOU is concerned by providing the required medical, operational and logistics support to these entities. In order to fulfil this role, DFS would require adequate resources for the entire United Nations field presence. The inherent advantages would include harmonization of the definition of medical capabilities and of resources available in the field, joint utilization of resources for efficiency and savings, as well as transferability of resources from one organization to another.

46. WHO informed the Inspector that when the management of dispensaries was decentralized to the country level (under the Resident Representative and/or Country Team) and on an inter-agency cost-sharing basis, it became unmanageable and no one was really held responsible or accountable; there were disagreements on the cost-share among various agencies. When management was centralized under UNDP at UNHQ, procurement for dispensaries was done globally by WHO. With decentralization, WHO did not regularly receive reimbursements for advance orders and this was one of the reasons why they terminated this practice.[23]

47. Similar concerns have been addressed by the Inter-Agency Security Management Network (IASMN) with regard to the limited resources in the United Nations system to manage, support and monitor field medical services. IASMN therefore supported and encouraged "the ongoing efforts of the Medical Directors Working Group to establish an infrastructure capable of ensuring adequate health care, including emergency medical services for United Nations system staff worldwide."[24] The Network further recommended that United Nations Medical Dispensaries be properly staffed and equipped to assist United Nations staff in the event of mass casualty incidents, by supplementing local response capabilities to the extent practicable.[25] UNMDWG also noted that the future strategic direction of the United Nations system included greater emphasis on field presence and staff mobility. This has critical implications for the health standards applied during the selection of staff, and the provision of supportive health-care services for staff deployed in areas with inadequate medical infrastructures.[26] The Inspector strongly supports the above-mentioned positions.

48. Implementation of the recommendation below would enhance the accountability of all stakeholders.

Recommendation 4

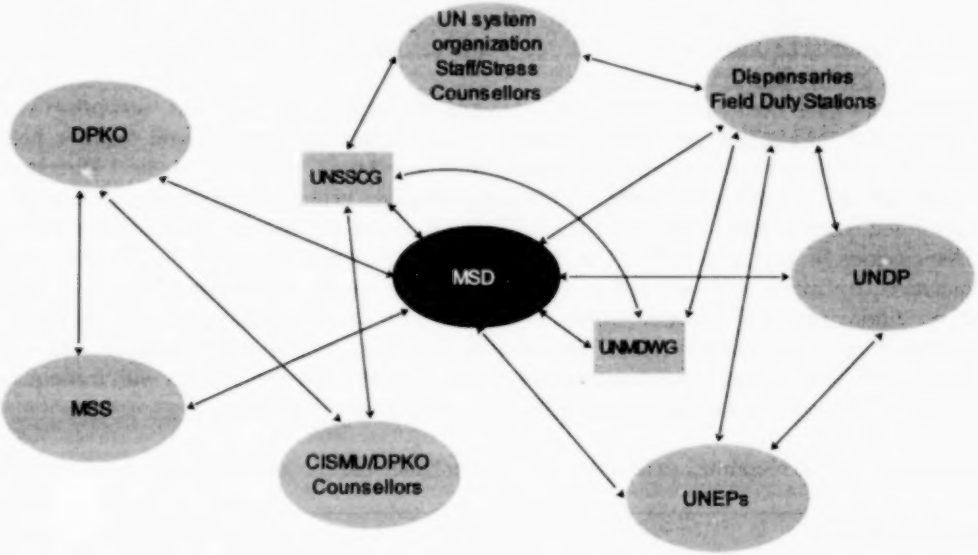
The Administrator of the United Nations Development Programme, in consultation with the United Nations Medical Services Division and UNMDWG, should finalize and adopt the Terms of Reference for the administration of United Nations dispensaries, thereby ensuring consistent and transparent management practices to meet the medical requirements of United Nations system staff concerned.

[23] WHO's response to the Inspector's questionnaire.
[24] Report of the Inter-Agency Security Management Network (Lyon, 28-30 July 2008), CEB/2008/HLCM/13, para. 50.
[25] Ibid., para 25.
[26] CEB/2009/HLCM/32, para 9.

E. Field medical service providers

49. Figure 5 below shows the linkages between field medical service providers. While MSD could be considered as the nucleus and linked to all, with the exception of the CISMU/DPKO counsellors, in fact, some providers do not interact with each other. It is clear from figure 5, and further elaborated in the text, that clear accountability and reporting lines are missing, hence the difficulty in obtaining system-wide coherence on the issue at hand. For example, MSS provides the necessary logistical support for DPKO medical facilities, yet they are not called on to provide similar services to dispensaries, where synergies could be maximized; indeed, United Nations dispensaries have no centralized logistical support, and each makes its own arrangements for procurement and supplies.

Figure 5
Field medical service providers - linkages



United Nations Medical Services Division

50. MSD is tasked with managing, supporting and monitoring a globally distributed health-care service which currently crosses departmental and organizational boundaries. It ensures staff worldwide access to health services by:[27]

- Advising on and assisting with medical evacuation and repatriation requests by staff and their recognized dependants, military observers, civilian police monitors and United Nations peacekeeping troops;

[27] ST/SGB//2004/8.

- Making periodic on-site assessments of local health facilities and living conditions at field duty stations and advising staff and administration accordingly;
- Advising on and assisting in establishing new United Nations field medical facilities, when and where necessary;
- Providing technical support to all United Nations medical facilities;
- Appointing and reviewing United Nations examining physicians in all duty stations;
- Evaluating and providing technical clearance for all candidates applying for medically related United Nations posts, including United Nations volunteers, nurses and medical technicians.

51. However, MSD faces challenges in undertaking the above roles. Indeed, the Secretary-General has noted that the capacity of the United Nations to manage, support and monitor a globally distributed health-care workforce is minimal.[28] Apart from resource constraints, issues concerning lines of authority, responsibility and accountability need to be addressed. Specifically, the majority of the United Nations health-care staff (doctors, nurses and paramedical staff) that MSD "oversees" actually work for different organizations, or in different departments. For example, physicians deployed in peacekeeping missions have contracts with the Department of Field Support, and physicians working in United Nations dispensaries have contracts with UNDP. The Inspector is of the view that it is very unlikely that MSD can effectively exercise authority, responsibility, and accountability over the staff it supervises when it has little, if any, influence in employment decisions, no input into budgets and work plans of field units, and no involvement in the performance management process of the various organizations concerned.

52. While medical services in most duty stations have relatively clear internal reporting lines, authority and accountability, the Inspector recommends (in Chapter V) the establishment of a network that would group all stakeholders involved under a single structure dealing with system-wide accountability. This also implies modifications to the current MSD mandate stipulated in the bulletin on Organization of the Office of Human Resources Management (ST/SGB/2004/8), taking into account its role in the proposed network, and the emphasis to be given to the implementation of OSH policies.

53. The implementation of the recommendation below would enhance the effectiveness of MSD.

Recommendation 5

The Secretary-General should amend ST/SGB/2004/8 to reflect the revised mandate and role of the United Nations Medical Services Division, ensuring effective implementation of Occupational Safety and Health policies and the United Nations global health-care system.

54. Prior to 2007, the only direct contact that MSD staff had with field physicians was limited to the six to eight budgeted assessment visits conducted by MSD per year. Considering the large number of facilities that actually fall under MSD's mandate of professional supervision, each facility could only be visited approximately once every eight years, falling far short of any reasonable managerial monitoring requirement. On noting the above-mentioned situation, the current Medical Director, who took office in 2007, instituted the practice of holding a regular annual meeting for all field physicians, one for United Nations dispensary physicians, and one for physicians from peacekeeping missions. Limited headquarters funding only covers the participation of MSD staff in these meetings; Country Teams and missions are requested to cover the participation cost of their respective physicians. The meetings are intended to provide the opportunity for direct

[28] A/65/305, 2 September 2010, para. 141.

interaction between headquarters and field medical staff, to facilitate explanation and coordination of United Nations medical policies and procedures, and to foster professional networking and communication among doctors who share similar difficulties and circumstances. In addition, the meetings are used for training and development purposes. For example, following the concerns expressed by medical directors regarding medical emergency preparedness in their report to the HLCM in February 2009,[29] MSD arranged internationally certified training in pre-hospital trauma and life support (PHTLS) at both of the field physician meetings in 2009. This was followed by a two-day tabletop simulation training during the 2010 meetings, covering communications and organizational management with regard to responding to crises and mass-casualty incidents. During the meetings planned for 2011, field physicians will be trained in how to adapt and apply planning templates for emergency preparedness at their own duty stations.

55. In order to further develop contact and communication for all United Nations health-care staff (field and headquarters), MSD should identify additional resources necessary to achieving this purpose, and submit a proposal to the Secretary-General through the appropriate channels, for onward transmission to the General Assembly for consideration.

United Nations examining physicians

56. MSD is responsible for appointing United Nations examining physicians (UNEPs), based on recommendations made by Resident Coordinators and WHO representatives, and issuing an updated list on an annual basis. The services of UNEPs are available to all United Nations system organizations; UNEPs are not given any formal contracts, and their fees for services provided are expected to be reasonable and customary.

57. The main functions of UNEPs include the performance of pre-employment medical examinations; periodic medical examinations; exit medical examinations (if required); assisting with medical evacuations, i.e. if a staff member or eligible dependant needs to be medically evacuated, a United Nations examining physician is required to make a recommendation to the Head of the Fund/Programme/Agency that the staff member belongs to; and assist with sick leave and other medical/occupational health issues.

58. While there are over 600 UNEPs in the field,[30] the Inspector notes that there is no systematic monitoring and evaluation of the services they provide, and the list is updated sporadically. MSD does assess UNEPs practising in the areas where they undertake missions (six to eight per year) to field locations, but this is a very small percentage of the full group. Some organizations have complained about the reliability of the list, since some UNEPs listed have either retired or are deceased. Organizations often rely on other health-care providers for the required services.

59. The implementation of the recommendation below would ensure control and compliance with the responsibilities assigned to MSD.

Recommendation 6

The United Nations Medical Services Division should develop an effective monitoring and evaluation tool for assessing the services provided by United Nations examining physicians and update the global list on an annual basis.

[29] CEB/2009/HLCM/17, 18 February 2009.

[30] Source: MSD's response to the Inspector's questionnaire.

Department of Peacekeeping Operations

60. The purpose of United Nations medical support for peacekeeping operations is to "secure the health and well-being of members of the United Nations peacekeeping operations through planning, coordination, execution, monitoring and professional supervision of excellent medical care in the field."[31] The medical support extended to DPKO personnel must meet standards that are acceptable to all participating nations, with the aim of providing a standard of care comparable to prevailing peacetime medical care. Such support, therefore, must maintain a high state of readiness and availability, providing timely, responsive and continuous care to any patient or casualty within the medical system.[32]

61. DPKO has adopted a four-level medical support structure with the classification level of a unit determined by its treatment capability and capacity (see annex III for a description). The allocation of medical resources is intrinsically linked to the peacekeeping mandate, type of peacekeeping operation, existing medical infrastructure, geographical factors, and assessed medical threats. Prior to the establishment of a peacekeeping mission, a technical survey is conducted in the potential mission area in order to determine the main medical threats, as well as the medical facilities/resources required to support peacekeepers and international staff in such an operation.

Peacekeeping mandate: Official United Nations policy is that there is no obligation to provide or take responsibility for medical services to the local population, though this is sometimes rendered according to the dictates of international humanitarian law, and the ethical code of the medical profession.[33]

Type of peacekeeping operation: While missions involving military observers/civilian police often do not require the deployment of a medical unit, those that are of a high-risk nature, such as peace enforcement and demining do.[34]

Existing medical and civil infrastructure: Where local hospitals and clinics within the mission area do not meet acceptable United Nations standards, or where these are not readily accessible, there is a requirement to deploy a higher level of medical support within the mission, regardless of its troop strength or deployment.[35]

Geographical factors: Terrain, accessibility by land and air, physical distance, climate and other geographical factors influence the level of medical support required and deployment within the mission area. Where there are good land communications and/or adequate air evacuation assets, local medical facilities and those in a nearby country may be utilized instead of deploying United Nations medical units. Where access is poor, medical units of varying sizes and capabilities may be deployed.[36]

Medical threat assessment: Deployed medical units should meet the daily health care needs of United Nations personnel in the field. As such, apart from treating minor ailments (primary health care) and endemic infectious diseases, they may be required to manage severe trauma and mass casualty situations. The latter may arise as a result of direct acts of hostility and where land mines are involved,

[31] DPKO/OPS/MSU, Medical Support Manual for United Nations Peacekeeping Operations (2nd edition), 1999, para. 1.01.
[32] Ibid., paras. 1.02 C and D.
[33] Ibid., para. 5.03 F.
[34] Ibid., para. 4.02 B.
[35] Ibid., para. 4.02 C.
[36] Ibid., para. 4.02 D.

particularly if civilians are treated under a humanitarian mandate. Thus deployments of field surgical units, radiology facilities, laboratories and blood banks may be warranted. It is also important to have dental facilities.

Medical services support – Department of Field Support

62. The Medical Support Section (MSS), Specialist Support Section (SSS) under the Logistics Support Division (LSD) of the Department of Field Support (DFS) is the executive arm of the United Nations for the planning, coordinating and monitoring of medical logistics support to field missions. It provides technical advice on all health-related issues to DFS/DPKO where it is integrated within their logistics systems; MSS also operates in close collaboration with MSD. Its core functions can be grouped into six areas: advisory; coordination; medical support planning for field missions; medical logistics; procurement; and training (see annex IV for a breakdown of activities).

63. DPKO issued the first edition of the Medical Support Manual for United Nations Peacekeeping Operations in 1995, with a revised edition in 1999, to provide a comprehensive reference document for planning, coordinating and executing medical support, as well as serve as a tool for training peacekeepers and medical personnel on the medical aspects of United Nations peacekeeping operations.[37] The current edition is being revised and will incorporate lessons learned from recent peacekeeping operations, and focus on improvement of the quality of medical services provided to peacekeepers, and on achieving greater efficiency in medical evacuation, within and out of a mission area.[38]

Critical Incident Stress Management Unit

64. The United Nations Department of Safety and Security, Critical Incident Stress Management Unit (UNDSS CISMU) was established as a distinct unit within UNDSS in 2000 further to a General Assembly mandate which expressly sought to address the needs of the increasing number of United Nations staff exposed to traumatic events while in service to the organization.[39] From a historical perspective, with the creation of the Office of the United Nations Security Coordinator (UNSECCORD) in 1988, the counselling role emerged as security officers began to provide such services to staff working in hazardous environments and facing security threats and psychosocial risks. It soon became evident that there was a need to secure the services of professional counsellors to look after staff affected by critical incidents. In this respect, the deployment of counsellors enhanced security operations, and in May 1994, the Administrative Committee on Coordination (ACC) concluded that "in view of the link between security incidents and critical-incident stress, the United Nations Security Coordinator should serve as the focal point for developing strategy to manage stress… and there should be a two-tiered strategy for stress-management: preventive stress management and critical-incident stress management."[40]

65. Based on the mandate given, CISMU has two key roles: strategic and operational. Regarding the former, it provides strategic guidance, design approaches and educational tools on critical incident stress prevention management to senior/line managers, organizations and security management teams in both headquarters and the field. With regard to the latter, it monitors and responds to critical incidents system-wide and provides

[37] Ibid., para. 1.05.
[38] A/64/643, para 42.
[39] A/RES/56/255.
[40] A/C.5/49/56, 16 February 1995, para. 3.

capacity building for staff on preventive stress management including preparedness to respond to psychosocial emergencies.

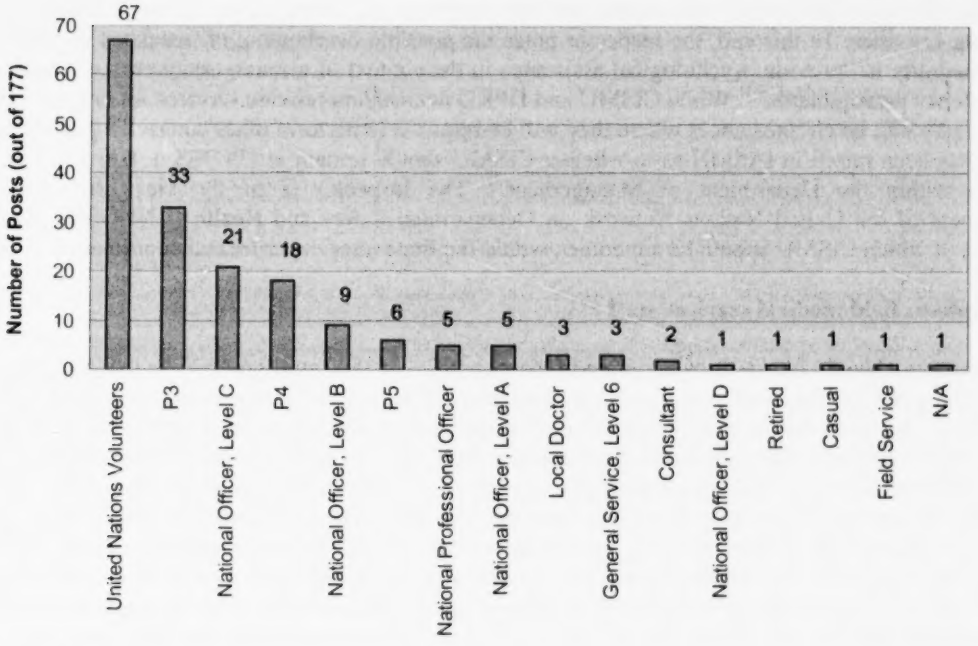
66. In addition to chairing the recruitment panels of the DPKO/DFS/DPA field staff counsellors, CISMU is responsible for their technical supervision and the system-wide coordination of their psychosocial and counselling activities. To this end, the Inspector notes the possible overlapping of mandates as MSD also has the responsibility to "provide psychological assistance in the context of mission assignments, substance abuse and emergency preparedness."[41] While CISMU and DPKO counsellors provide services for critical incidents in the field, there will be circumstances where they will be required to perform other counselling services. In fact, the issue has been raised in IASMN as to whether CISMU should remain in UNDSS or be moved to MSD or elsewhere within the Department of Management.[42] The Inspector is of the view that the proposed establishment of the United Nations Network on Occupational Safety and Health (UNNOSH), discussed in Chapter V, of which CISMU should be a member, would facilitate inter-departmental coordination in this area.

United Nations field medical services staff

67. The Inspector would like to draw attention to the disparities in field staff grading. To this end, figures 6 and 7 below show the staffing and post levels of medical staff serving in peacekeeping missions and country offices. As is the case for medical directors at headquarters, a similar harmonization for medical staff is required. This is of particular relevance to field medical staff, who are often isolated from collegial support and specialist referral networks, and whose decisions can have life or death consequences. Dispensary and civilian clinical physicians have expressed dissatisfaction with the post-level discrepancies between duty stations of posts with similar levels of responsibility, as well as with the overall lack of recognition of the high level of responsibility required.[43] In addition, there is no system of organized career progression, and marked job insecurity exists.[44] OIOS also expressed similar concerns during their meeting with the Inspector; they felt that some dispensary doctors were given responsibilities that were not commensurate with their post levels.

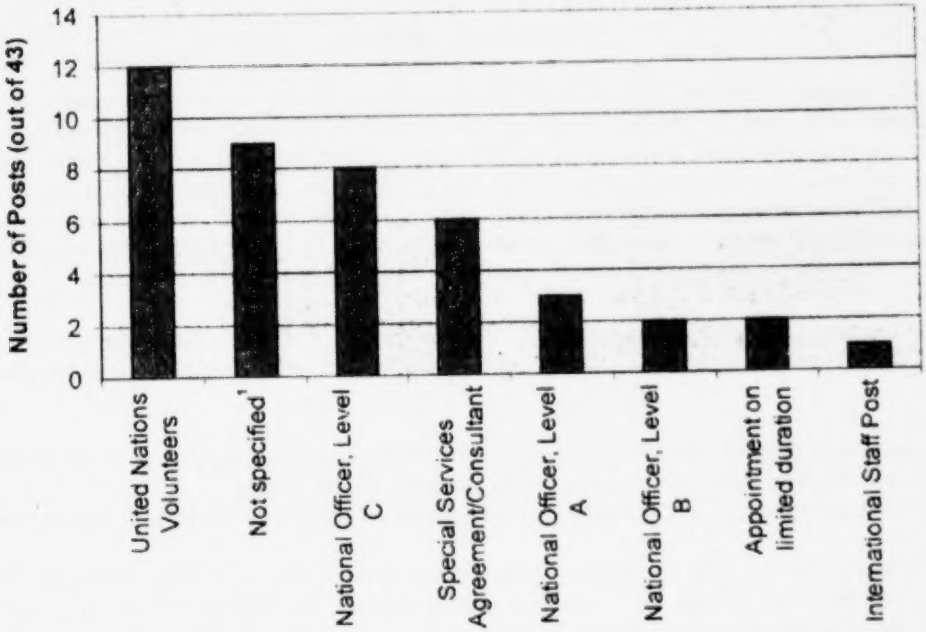
[41] ST/SGB/2004/8, para. 7.1.
[42] Minutes of IASMN Meeting, Nairobi, 1-5 February 2010, para. 72.
[43] UNMDWG, Statement on Field Health Care (Washington DC, March 2008), Attachment 1, CEB/2009/HLCM/17, 18 February 2009.
[44] Ibid.

Figure 6
Health-care staff post levels at United Nations Peacekeeping Missions (as of September 2010)



Source: MSD

Figure 7
Physician post levels at United Nations dispensaries
(as of June 2010)



[1] As contracts are given by Resident Coordinator, the exact post level is not known by the Chief Medical Doctor.

68. The majority of the medical service posts in the field are held by United Nations volunteers. These staff are professionally competent and motivated, and perform basically similar functions at different locations, all under different contractual arrangements and, in some cases, with precarious durations and conditions. For credibility purposes, and to ensure the stability and range of essential services, the contractual status of all medical staff must be reviewed to ensure fairness and equality across the entire system.

F. Deep field

69. UNHCR and WFP pointed out to the Inspector, during his mission to Liberia, that while medical facilities are normally available at most duty stations, the same cannot be said for all. Some locations are remote and medical services are limited. For these "deep field"[45] areas where access to such services is difficult, top priority should be given by the organizations to ensuring that basic and emergency medical services are available to, or within easy/reasonable access by, staff based there.

[45] Expression originally used by UNHCR, and which has now obtained widespread acceptance/usage within the United Nations system.

70. UNMDWG has been requested to provide a set of Medical Minimum Operating Standards which should be adapted for inclusion in the Minimum Operating Safety and Security Standards (MOSS).[46] Their inclusion into MOSS and subsequent implementation will result in additional costs for those organizations with staff in "deep field" areas. The Inspector notes that such costs are not only unavoidable but necessary.

G. Case study - Liberia

71. Current JIU budget restrictions prevented the Inspector from visiting an adequate sample of field duty stations. To compensate, however, the Inspector sought the views of staff associations, in particular those with a field presence. He wishes to thank, in particular, the headquarters staff associations of FAO, WFP and UNICEF for obtaining feedback from their respective field counterparts. The main view, shared by all, was that headquarters staff were privileged, in that most of the services available to them were not available to the field staff. The Inspector also obtained information on medical facilities in selected field duty stations, based on confidential evaluation reports prepared by WHO and MSD, for which gratitude is expressed.

72. The following paragraphs contain the Inspector's impressions of his site visit to the United Nations Mission in Liberia (UNMIL) and highlight the challenges it faces, which are perhaps similar in other peacekeeping missions.

73. Local hospitals and medical facilities in Liberia are poorly equipped and are incapable of providing many required services. Medical emergency services are limited; blood supply is unreliable and unsafe for transfusion; medicines are scarce, often beyond expiration dates, and generally unavailable in most areas.

74. United Nations personnel rely on services provided by UNMIL resources. Due to a lack of advanced medical diagnostic facilities, UNMIL still evacuates patients to Accra (Ghana) for routine investigations. Poor environmental hygiene and the lack of access to safe water and sanitation facilities are the most serious risk factors for infectious diseases. Peacekeepers and United Nations staff are affected by food and water-borne diseases. Malaria is one of the major health risks encountered by personnel there.

75. The United Nations dispensary services all United Nations staff members and their dependents. Attendance increased from 1,963 in 2008 to 3,292 in 2009, which resulted in considerable depletion of consumables (drugs, supplies, vaccines), and the dispensary has run out of many essential drugs that must be replenished urgently.

76. The following operational challenges were mentioned by the UNMIL medical service:

- Due to insufficient staffing of the medical section, United Nations Level 1 clinics in some regions are operating with a single doctor or a nurse;
- Unavailability of competent medical suppliers locally to support the huge number of UNMIL medical facilities in case of urgent need;
- Unavailability of contracted (global) air medical evacuation facilities to transport critical patients to a Level 4 hospital;
- Provision of medical support in some sectors in Liberia depends on medical support from troop contributing countries (TCCs). However, the specific TCC medical facilities in the region do not take this into consideration when sourcing drugs and other medical supplies;

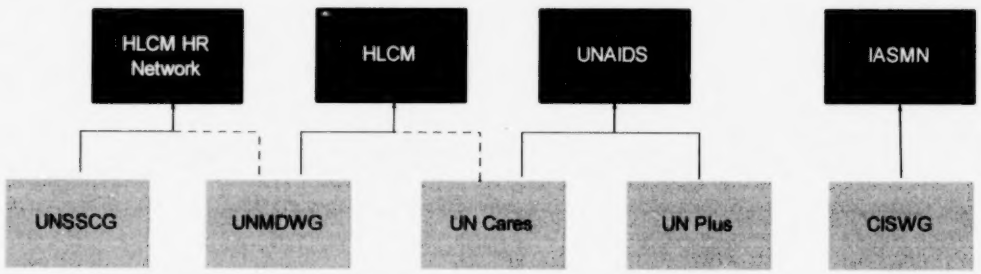
[46] CEB/2009/HLCM/17, 18 February 2009, para. 3.

- There are no training facilities for continuous medical education in the country for medical professionals; programmes to ensure ongoing medical skills maintenance and development should be designed and implemented;
- Certification of medical staff should be reviewed by the United Nations. As medical professionals are recruited worldwide, having doctors and nurses practicing in a uniform manner is at times difficult.

IV. CURRENT SYSTEM-WIDE MEDICAL SERVICE COORDINATION/COOPERATION

This chapter describes the various system-wide/inter-agency bodies that coordinate/cooperate on Medical/OSH services. Figure 8 below indicates the absence of a system-wide "umbrella" coordinating body.

Figure 8
System-wide and inter-agency medical/OSH bodies



A. United Nations Medical Directors Working Group (UNMDWG)

77. In existence since 1996, UNMDWG was formally established and recognized by HLCM in March 2005.[47] It adopted a statement of purpose which established its mandate in broad terms. The working group is composed of, but not limited to, the medical directors of the United Nations and the specialized agencies, and includes the medical directors of other inter-governmental development agencies.[48]

78. Its objectives are to optimize the health and well-being of the staff of the United Nations, specialized agencies and inter-governmental organizations through collaboration and coordination of their medical services.[49]

79. The group, which meets once a year and is chaired traditionally by the United Nations Medical Director, promotes and shares medical, technical and professional knowledge and resources in the area of occupational health; promotes best practices and procedures of the medical services; initiates and harmonizes proactive occupational health policies throughout the United Nations common system; and presents recommendations and expert advice to member organization administrations, and appropriate bodies of the common system.[50]

80. There are no specific costs/commitments required for group membership; members are expected to cover their own travel costs to attend meetings. The World Bank, from inception in 1996, and FAO thereafter, have provided secretariat services on a pro bono basis. The World Bank is hosting/updating the group's website.

[47] CEB/2005/3, 23 May 2005, para 76 (b).
[48] The UN Medical Directors Group, document submitted by FAO, CEB/2005/HLCM/R.12, 24 March 2005.
[49] Ibid., para. 5.
[50] Ibid., para. 6.

81. UNMDWG recently submitted a series of papers to HLCM aimed at drawing attention to the working group's concerns regarding emergency medical management; the capacity of the United Nations to support, monitor and manage the globally distributed workforce of the United Nations health-care staff; and the need for a safety and health policy in the United Nations system.[51] These papers have been endorsed by HLCM.[52]

82. The working group has also produced a plethora of position and policy guidance statements over the years on topics such as screening and testing of HIV/AIDS; continuing professional development of medical staff; guidance for upgrade of travel class for medical reasons; medical confidentiality; and employment of disabled persons. In 2002-2003, the working group coordinated an inter-agency project to facilitate health education, prevention and care for HIV/AIDS for United Nations staff and their families; the final outcome of the project contributed to the creation of UN Cares.[53]

B. United Nations Staff/Stress Counsellors Special Interest Group (UNSSCG)

83. The group is comprised of mental health professionals and social workers employed as staff/stress counsellors in the United Nations system and related organizations.[54] Its mission is "to promote the psychological and social well-being and welfare of the staff and the organizations."[55]

84. The group's first meeting was organized by WFP in 2000, when they invited counterparts from other organizations to join and share their work experiences and visions about the future direction of staff counselling in the United Nations system. CEB formally recognized the group as part of the Human Resources Network (HRN) at the HRN meeting in February 2010.[56]

85. Like UNMDWG, there are no costs/commitments for group membership. Members are expected to cover their own costs to attend annual meetings and participate in working group meetings. The Inspector encourages organizations to support the participation of their staff counsellors in these meetings, thereby ensuring adequate system-wide participation and fulfilling the group's mandate as endorsed by the HRN.

86. The Inspector welcomes the formal training sessions that the group organizes for its members to coincide with their annual meetings. Identification and communication of professional and technical standards, and providing opportunities for relevant continuing education, should continue to be one of the cornerstone activities of the group. The group's proposal on Confidentiality Guidelines for the United Nations Staff/Stress Counsellors has been adopted by HRN[57] and the group is currently finalizing a proposal on Guidelines for Staff/Stress Counselling Services in the United Nations system.[58]

C. Critical Incident Stress Working Group (CISWG)

87. UNDSS, and its predecessor, the Office of the United Nations Security Coordinator (UNSECOORD), were mandated by the General Assembly to "ensure that all United Nations staff members receive adequate security

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[51] CEB/2009/HLCM/17, 18 February 2009; CEB/2009/HLCM/32, 15 September 2009; CEB/2010/HLCM/11, 11 February 2010.

[52] CEB/2009/3, 23 March 2009; CEB/2009/6, 21 October 2009; CEB/2010/3, 15 March 2010.

[53] Guideline for providing access to care and treatment for HIV/AIDS to UN system employees and their families, WHO publication, 2004.

[54] United Nations Staff/Stress Counsellors' Group – Mandate, Annex 2, CEB/2010/HLCM/HR/18, 28 March 2010.

[55] UNSSCG Statement of Purpose, reviewed and finalized at the annual meeting of September 2003.

[56] Conclusions of the Meeting of the Human Resources Network, CEB/2010/HLCM/HR/18, 28 March 2010.

[57] CEB/2010/HLCM/HR/35, 27 September 2010, paras. 110 and 111.

[58] UNSSCG's response to the Inspector's questionnaire, July 2010.

training, including physical and psychological training prior to their deployment in the field and … through the implementation of a comprehensive security and stress and trauma management training, support and assistance programme for United Nations staff throughout the system, before, during and after missions."[59] Thus, in order to ensure a coordinated and coherent response to critical incident stress management, IASMN endorsed the establishment of CISWG in April 2005, as the governing and coordinating body to formulate policy and standards for submission to IASMN for decision.

88. CISWG members, nominated by their respective security focal points, develop and promote policies to enhance the provision of critical incident stress prevention and management in order to improve the psychosocial well-being of staff in the United Nations system, and improve coordination between UNDSS staff/stress counsellors and security through IASMN.

89. To date, CISWG has produced a document on standard operating procedures and a strategic framework on critical incident stress, as well as a paper on critical incident stress management, and guidelines on communication in crisis and non-crisis settings.

D. UN Cares

90. Established as an outcome of a coordinated UNMDWG/WHO project,[60] UN Cares is the system-wide workplace programme on HIV that provides United Nations personnel and their families with access to information, learning opportunities, preventive commodities, and post-exposure prophylaxis (treatment taken immediately after exposure to HIV in an effort to prevent infection) as established by the *UN Cares 10 Minimum Standards*. The Minimum Standards serve as a model for the United Nations reform process by "delivering as one" an HIV workplace programme that builds on existing workplace efforts of various United Nations agencies, while eliminating duplication of effort.[61]

91. In operation since 2008 and funded by 21 international organizations, UN Cares estimates that by 2013, participating organizations could accumulate combined savings of close to USD 36 million.[62] This would be in the form of a reduction in costs related to "funerary benefits, death benefits, and recruitment and training for new workers required to replace those who are unable to work with AIDS."[63]

92. The Inspector notes that the current UN Cares programme budget (approved by HLCM) is funded on a 50 per cent basis to the tune of only USD 2.6 million.[64] He noted that the United Nations Secretariat had not yet paid its contribution of USD 350,000 (although the funds had been requested) for the 2010/2011 budget.[65] The Secretary-General has made UN Cares a priority, and has stated his determination to make the United Nations a model of how the workplace should respond to HIV.

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[59] A/RES/57/155, 3 March 2003, para 21.

[60] See footnote 53 above.

[61] Living in a world with HIV: Information for UN system personnel and their families, UNAIDS, second revised reprint 2009. See also www.uncares.org.

[62] UN Cares: The Programme on HIV in the UN System Workplace, Current Status 2010-2011 and Strategy Beyond 2011, CEB/2010/HLCM/HR/29, 28 June 2010.

[63] The Financial Impact of HIV and AIDS on the UN Workplace, available at www.uncares.org.

[64] UN Cares: The Programme on HIV in the UN System Workplace, Current Status 2010-2011 and Strategy Beyond 2011, CEB/2010/HLCM/HR/29, 28 June 2010.

[65] Ibid., p. 5.

93. While the success of UN Cares is dependent on the leadership and action of all participating members, the Inspector noted that contribution by all would permit the agreed external evaluation of the programme to be carried out in 2011.[66]

E. UN Plus

94. On the recommendation of the UN Cares Task Force, UN Plus was established in 2005 as part of the United Nations Reform in action with the mission statement, "Uniting for Solidarity, equality and acceptance for people living with HIV within the United Nations system through awareness raising, policy change and advocacy."[67]

95. In order to achieve its stated objectives of (i) creating a more enabling environment for all HIV-positive staff members, irrespective of the level of disclosure of their HIV status; (ii) creating an organized and effective voice for people living with HIV within the United Nations system that challenges stigma and discrimination; and (iii) contributing to the development and/or improvement of existing policies on HIV among United Nations agencies, over 30 UN Plus members from 11 organizations met in 2006 to address the challenges faced in four key areas: confidentiality; mobility and travel; health insurance; and stigma and discrimination.

96. The position papers prepared and published in 2007 address the realities and needs of United Nations staff members and their immediate families affected by HIV and AIDS, as well as provide guidance for policy makers entrusted with implementing/modifying the 1991 United Nations Personnel Policy on HIV/AIDS to meet the requirements of their respective organizations.

[66] UN Cares: The Programme on HIV in the UN System Workplace, Current Status 2010-2011 and Strategy Beyond 2011, CEB/2010/HLCM/HR/29, 28 June 2010, p. 5.

[67] UN Plus homepage at www.unplus.org.

V. TOWARDS A SYSTEM-WIDE MEDICAL SERVICE/ OCCUPATIONAL SAFETY AND HEALTH COORDINATION AND COOPERATION MECHANISM

97. The adoption of OSH policies will require the centralization of distinct OSH services under one umbrella, not only at the organizational level, but also at the system-wide level, so as ensure effective coordination and implementation. This is particularly the case for system-wide implementation, as current practice is hampered not only by the absence of a system-wide mechanism, but also by the fact that the fragmentation (in lines of authority) of medical/OSH services provided by United Nations system organizations is not conducive to service level optimization.

98. Using the following example as an illustration, the Inspector reiterates the need for a system-wide body to coordinate and assume responsibility for a system-wide medical response.

99. The recent H1N1 influenza pandemic provided an important opportunity for the United Nations Medical Services to experience and assess the complex processes needed for a centralized system-wide procurement exercise for common medical supplies within the United Nations system.

100. In September 2009, the difficulties encountered by United Nations staff in accessing the H1N1 vaccine was discussed by the High-Level Steering Committee on Influenza at a meeting chaired by the Deputy Secretary-General. At the time, the United Nations found itself in a uniquely unfavourable situation, because of the reduced yield by the candidate H1N1-vaccine virus in eggs (resulting in massive underproduction of vaccines), the already existing shortage of global vaccine manufacturing capacity, and huge bulk purchases made in advance by governments (accounting for all available and immediately prospective vaccine-production quotas). **Only governmental or linked organizations were able to purchase the vaccines at the time.**[68] The Steering Committee on Influenza therefore decided that a way forward should be found to ensure that United Nations staff and their dependents, particularly those in remote locations, had equitable access to the H1N1 vaccine.

101. From that first meeting of the Steering Committee on Influenza, it was another three months before an agreed approach and way forward could be decided and formally endorsed. During that period, an inter-agency task force considered issues such as legal liability, priority groups to access the vaccine, and mechanisms for central procurement, distribution and administration of the vaccine. Following endorsement of a plan in December 2009, another three months were needed to negotiate and finalize a Memorandum of Understanding between the United Nations Secretariat and UNICEF, which had agreed to be the lead agency for procurement and worldwide distribution of the vaccine. The MOU was signed on 9 April 2010, but further delays occurred as DPKO required another three months for redeployment of associated funds from their missions back to UNHQ, and more time to transfer those funds from UNHQ to UNICEF. In fact, up to November 2010, more than a year after the pandemic outbreak, efforts were still underway to acquire vaccine stocks and ship them to staff in some remote DPKO locations.

102. In the Inspector's view, the above scenario constitutes an unacceptable delay, and there is clearly a strong need to improve the United Nations system's processes to prevent and avoid the recurrence of such long delays,

[68] Noni Macdonald, "H1N1 influenza vaccine: Global access for a global problem". Editorial, Canadian Medical Association Journal, 181 (3-4), August 4, 2009, available at http://www.cmaj.ca/cgi/reprint/181/3-4/123; and based on MSD's exploratory discussions with pharmaceutical companies, Novartis and Sanofi-Aventis.

whether the need is related to medical supplies for a flu pandemic, a natural disaster, or other medical emergency.

103. The above case highlights the need for a centralized, properly structured and funded procurement system for medical supplies, which would increase efficiencies of bulk purchasing, reduce unnecessary and duplicated administration, and minimize such delays in the future. Designated buyers at headquarters would be able to work directly with vendors to purchase medical supplies on behalf of United Nations entities, and effect immediate transfer of payment to vendors, as might be called for in a crisis. A centralized procurement system would provide a standardized, economical system for acquisition and distribution of commonly used medical supplies for use by United Nations staff globally, and a reduction in administrative costs through elimination of duplication in purchasing staff, records and procedures.

104. For security-related issues, the United Nations system established IASMN, which brings together senior managers of all partners in the United Nations security management system, including agencies, funds and programmes, to coordinate security practices and policies across the United Nations system. The Inspector is of the opinion that a similar network should be instituted for OSH-related issues, and to that effect, the Secretary-General should submit a formal request to the General Assembly for its establishment.

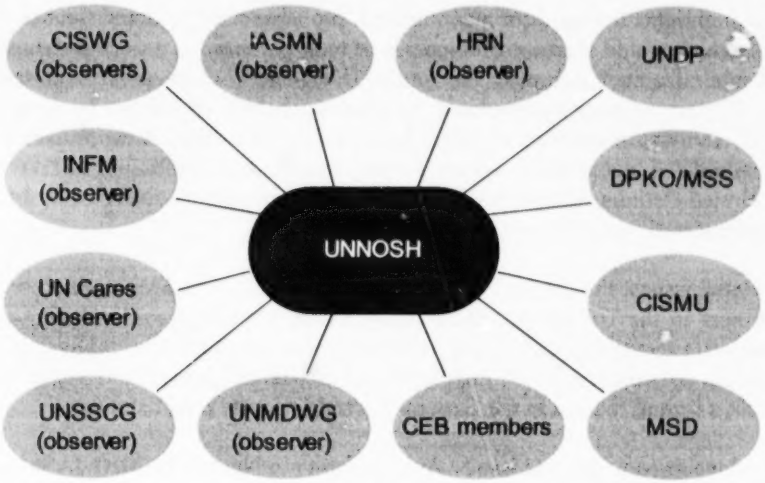
105. IASMN is also concerned with OSH issues. At its meeting in Nairobi in 2010, IASMN strongly supported the cross-disciplinary initiative to "develop a comprehensive and well-managed relevant occupational health and safety framework for the United Nations system, and requested UNMDWG to provide an update on its progress at their next meeting."[69] UNMDWG is aware that the draft Medical Minimum Operating Standards needs to be adapted to the concept and structure of the Minimum Operating Security Standards (MOSS).[70] Further to the above, the establishment of a coordinating body would be the enabling mechanism to achieve this goal.

106. The proposed coordinating body, the United Nations Network on Occupational Safety and Health (UNNOSH), derived from the IASMN model, would provide support to HLCM in its comprehensive review of policies and resource-related issues pertaining to the entire United Nations occupational safety and health structure, which is an important item on its agenda.

107. UNNOSH would bring together senior managers who have managerial oversight of the occupational safety and health functions within the bodies shown in Figure 9 below.

[69] Minutes of the IASMN meeting, Nairobi, 1-5 February 2010, para. 89.
[70] CEB/2009/HLCM/17, 18 February 2009, para. 3.

Figure 9
Suggested membership of the proposed UNNOSH



UNNOSH should include all CEB member organizations, as well as those organizations which have concluded a Memorandum of Understanding with the United Nations for the purposes of participating in the United Nations OSH structure. It should also include United Nations Staff Federations (observer status) and any organization or department which has a specific mandate to manage the occupational safety and health of United Nations staff, or which are directly involved in the coordination, delivery and support of United Nations activities in the field, especially during emergencies and in high-risk environments. WHO and ILO, both having recognized mandates in the OSH field, should play key supporting roles in UNNOSH.

108. UNNOSH should monitor the implementation of United Nations OSH policies, practices and procedures by all actors of the United Nations system, including the related programme budget, and report and make recommendations thereon to HLCM.

109. The implementation of the following recommendation would enhance the coordination, cooperation and accountability of stakeholders.

Recommendation 7

The General Assembly should mandate the Secretary-General to create the United Nations Network on Occupational Safety and Health, with a defined Terms of Reference, and which should be headed by the United Nations Chief Medical Director.

110. The Inspector notes that the expansion of OSH-related matters and the lack of resources will impact the effectiveness of the network, and **strongly** recommends the creation of a small UNNOSH secretariat consisting of one professional and one general service staff within MSD.

111. The Inspector is of the view that existing system-wide mechanisms, such as UNMDWG, UNSSCG and CISWG, continue with their present mandates and focus on their specific subject areas, rather than be merged under UNNOSH. Areas of overlap should therefore be discussed at UNNOSH.

112. As UNNOSH will be the first inter-agency policy-making group to address system-wide OSH, it will have to address a wide range of issues, and advise on policy and procedural guidelines as required. The list below, which is not exhaustive, illustrates the magnitude of the task ahead, as well as the potential negative impact of continuing to operate without systemic coordination and management of OSH:

- Guidance and monitoring regarding overall OSH policies, and their implementation system wide;

- Introduction of risk management principles for both occupational health and safety, and promotion of individual health and well-being;

- Guidance on ethical standards for OSH in general, and specific occupational sub-groups (e.g. doctors, nurses, counsellors, etc);

- Issuance of professional standards for OSH practitioners (entry standards for employment, continuing development standards for skills maintenance/updating, and professional certification);

- Provision of continuing professional development training to achieve skills maintenance standards;

- Guidance for adjudication of professional disputes and/or challenges regarding ethical and professional standards of care;

- Development of health-care facility standards (for facilities accessible by United Nations staff);

- Development of standards regarding OSH working environment and conditions in United Nations workplaces (e.g. ergonomics of workplace equipment, lighting, noise, etc);

- Good practice guidelines for OSH facilities, including confidentiality issues, and standardization of electronic medical and health-care record systems;

- Establishment of a decentralized management structure enabling development, support, oversight, and monitoring of a predominantly field-based OSH system;

- Formulation of recommendations regarding job descriptions, post levels, and career development for OSH staff;

- Establishment of a reliable and responsive centralized procurement process for medical and health-care supplies;

- Re-evaluation of current traditional medical procedures and services, with a view to adapting to a more modern approach of preventive OSH (e.g. regarding sick leave, medical clearance, etc);

- Evaluating and recommending outsourcing options to avoid conflicts of interest (e.g. simultaneous provision of health-care, and adjudication of insurance benefits for staff);

- Improving pre-travel and pre-deployment risk assessment procedures, and individual preparedness and resilience for hardship missions;

- Reviewing and advising on organizational management of psychosocial health issues, including substance abuse;

- Providing system-wide guidance on emergency medical preparedness and response, including for pandemics, mass casualty incidents, and other public health emergencies;

- Coordinating a system-wide approach to medical evacuation;

- Reviewing and advising on the medical aspects of organizational policies and approaches to HIV/AIDS;

- Reviewing, advising, and coordinating a system-wide approach to compensation for service-incurred injury and illness, disability benefits, and special benefits (e.g., special education grant and grants for disabled children).

ANNEXES

Annex I

Medical services and programmes provided at headquarters duty stations (as of June 2010)

	Emergency/Primary Care	Vaccination	Periodic Medical Examination	Medical Clearance	Travel Briefing	Certification Sick/Maternity Leave	Health Promotion	Medical Evacuation	First Aid Training	Ergonomics	Disability Assessment	Entry Medical Examination	HIV/AIDS Counselling	Walk-in Clinic	Screening Programmes	Psychological/Social Assistance	Stress Management	Fitness Center	Laboratory
ECA	x	x	x	x	x		x	x	x	x		x	x		x	x		x	x
ECLAC	x	x	x	x	x	x	x	x	x	x	x		x	x	x		x		
ESCAP	x	x	x	x	x	x	x	x	x	x		x	x	x		x			
ESCWA	x	x	x	x		x	x	x	x	x	x		x	x					
FAO	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x
IAEA	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x			
ICAO	x	x	x	x	x	x	x	x	x		x	x				x	x	x	
ICTR	x	x	x		x	x	x		x			x		x		x	x		x
ILO	x	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	
IMO	x	x					x						x		x		x		
IOM	x	x	x		x	x	x	x	x	x	x					x	x	x	
OPCW	x	x	x	x	x	x	x		x	x	x				x			x	
UNESCO	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
UNHCR	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x
UNHQ	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x
UNOG	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	3x	x
UNON	x		x	x	x	x		x			x	x		x					
UNRWA			x	x								x							
WFP	x	x	x	x	x	x		x	x	x	x	x	x	x	x		x	x	x
WHO	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x
World Bank	x	x		x	x	x	x	x		x			x	x	x	x	x	x	x
TOTAL	**20**	**19**	**19**	**18**	**18**	**18**	**18**	**17**	**16**	**16**	**15**	**15**	**15**	**14**	**14**	**14**	**14**	**12**	**9**

Source: Organizations' response to the Inspector's questionnaire.

Annex II
Services generally expected of on-site United Nations dispensaries

a) Primary clinical care to United Nations system personnel

- **(i)** First aid and emergency services in response to accidents occurring in the workplace;
- **(ii)** Consultation and treatment for acute medical conditions for walk-in patients;
- **(iii)** Ongoing management or assistance with follow-up of chronic medical conditions diagnosed and for which treatment has already started;
- **(iv)** Necessary diagnostic tests required by clinical conditions, either on-site or through locally available laboratories;
- **(v)** Facilitation of staff access to local medical facilities and ensure follow-up.

b) Occupational health services

- **(i)** Promote health of staff, ensuring medical compatibility with job requirements;
- **(ii)** Provide travel medical services for staff on official travel, incorporating destination-specific health advice, immunization, prophylactic medications and travel medical kits;
- **(iii)** Advise staff about all medical and health issues related to their work;
- **(iv)** Assess and respond to staff concerns regarding health and ergonomic aspects of their workplace, and other matters related to work environment;
- **(v)** Conduct preventive health and health-promotion programs, such as blood pressure monitoring, screening of diabetes and smoke cessation;
- **(vi)** Contribute to induction and other health-related training, such as first aid training, CPR, etc.;
- **(vii)** Provide continuous support and assist in fully implementing the activities and programmes related to UN HIV/AIDS personnel policy.

c) Advisory services to management of all United Nations agencies

- **(i)** Recommend and arrange for medical evacuation to the recognized regional medical evacuation centres;
- **(ii)** Provide advice on sick leave issues;
- **(iii)** Provide advice on and assist with reasonable work accommodation for staff who are not able to carry out his/her regular duties full time for a specific period;
- **(iv)** Provide medical advice for disability cases, special dependency, work-related illness or injury and education benefits;
- **(v)** Verify appropriateness, reasonableness and customary nature of medical bills.

d) Other services

- **(i)** Organize periodic orientation sessions with all staff on the services provided by the United Nations dispensary;
- **(ii)** Create and update a one-page flyer on their mission and services, including contact information and hours of service;
- **(iii)** Supply, replenish and update all medical kits for all duty stations within the country, including medical kits for United Nations official vehicles;
- **(iv)** Systematically access and liaise with local medical facilities; establish a referral list and update it regularly.

Source: UN Dispensaries Draft, UNDP Office of Human Resources, Bureau of Management, 8 July 2009 update.

Annex III
Description of United Nations levels 1 to 4 medical facilities

- **Level 1 Medical support facility**

A Level 1 medical support facility is the first level of medical care which provides primary health care, and immediate lifesaving and resuscitation services. It is the first level of medical care at which a doctor or physician is available. It has the capacity to provide treatment to 20 ambulatory patients per day, a holding capacity of 5 patients for up to 2 days, and medical supplies and consumables for 60 days. The actual composition and number of Level 1 medical personnel may vary depending on operational requirements and agreed in the MOU. However, the basic manpower proposal (including the capability of splitting into two forward medical teams (FMT), each comprising 1 doctor and 2 to 3 paramedics) is 2 medical officers, 6 paramedics/nurses, and 3 support staff.

- **Level 1+ Medical facility**

In accordance with specific mission requirements, a Level 1 medical facility can be upgraded to Level 1+ by the addition of supplementary capabilities that enhance the medical support facilities. Services are reimbursed separately, in accordance with the Contingent Owned Equipment (COE) Manual and the MOU. Examples of additional capabilities include:

- Primary dental care
- Preventive medicine
- Basic laboratory testing
- Aero-medical evacuation team
- Surgical capability (forward surgical module) — only in exceptional situations, as required by exigencies of medical service support; additional patient holding capacity and deployment should be based only on the requirements of DPKO/DFS.

- **Level 2 Medical support facility**

A Level 2 medical support facility corresponds to the next level of medical care, and is the first level at which basic surgical expertise is available, and life support services and basic hospital and ancillary services are provided within the mission area. A Level 2 medical support facility provides all Level 1 capabilities in addition to emergency surgery, life and limb saving surgery, post-operative services, high-dependency care, intensive care resuscitation, in-patient services, as well as basic imaging services, laboratory, pharmaceutical, preventive medicine and dental services. Patient record maintenance and tracking of evacuated patients are also minimum capabilities at a Level 2 medical support facility. It has the capacity to perform 3 to 4 surgical operations per day, hospitalization for 10 to 20 sick or wounded for up to 7 days, examine up to 40 outpatients per day, 5 to 10 dental consultations per day, enough medical supplies, fluids and consumables for 60 days. The actual composition and number of Level 2 medical personnel may vary depending on the operational requirements, and agreed in the MOU. However, the basic manpower proposal is 2 surgeons (one general; one orthopaedic); 1 anaesthetist; 1 internist; 1 general physician; 1 dentist; 1 hygiene officer; 1 pharmacist; 2 head nurses; 2 intensive-care nurses; 1 operation theatre assistant; 19 nurses/paramedics; 1 radiographer; 1 laboratory technician; 1 dental assistant; 2 drivers; 8 support staff.

- **Level 2+ Medical facility**

A Level 2 facility can be enhanced to Level 2+ by augmentation with additional capabilities that enhance the medical support facilities. Services are reimbursed separately, in accordance with the COE Manual and MOU. Examples of additional capabilities include:

- Orthopaedic capability
- Gynaecology capability
- Additional internal medicine capability
- Additional diagnostic imaging capability (CT scan)

Level 2 or Level 2+ medical facilities may be provided by a troop/police contributor, a United Nations-owned medical facility, or commercially contracted.

- **Level 3 Medical support facility**

A Level 3 medical support facility corresponds to the third and highest level of medical care deployed within a mission area. A Level 3 facility has all the capabilities of a Level 1 and a Level 2 medical support facility, in addition to capabilities for multi-disciplinary surgical services, specialist services and specialist diagnostic services, increased high-dependency care capacity and extended intensive-care services, specialist outpatient services, maxillofacial surgery.

- **Level 4 Medical support facility**

A Level 4 facility is the highest level medical care facility that provides definitive medical care and specialist treatment in all fields of surgery and medicine.

Source: MSD

Annex IV
Core functions of the Medical Support Section

A. Advisory
- Advise DPKO/DFS, DPA and field missions on all medical support planning and logistics matters
- Develop medical support policies, doctrine, and guidelines

B. Coordination
- Plan and coordinate the medical logistic component of United Nations global medical support in collaboration with UNHQ departments, TCCs and United Nations agencies, for new, ongoing and liquidating missions

C. Medical support planning for field missions
- Participation in technical assessment and evaluation of field missions
- Develop medical support concept
- Develop medical support plan
- Develop and review of standard operating procedures and guidelines
- Pre-deployment medical assessment for TCCs and PCCs
- Briefing of TCCs and PCCs and medical requirements
- MOU/ Letter of Agreement (LOA) negotiations
- Implementation of medical support plan
- Assessment of medical facilities in start-up, ongoing and liquidating missions
- MSS desk officers at UNHQ provide oversight to missions in the implementation of the medical support plan

D. Medical logistics
- Missions budgeting and finance for medical support
- Develop material resource plan
- Develop material acquisition plan
- Manage strategic deployment stock
- Manage mission medical assets for start-up, ongoing and liquidating phases
- Develop material disposition plans
- Provide briefing on medical support matters to LSD director
- Provide medical support component in strategic planning exercises, i.e. DFS global field support strategy, benchmarking study, roadmap for medical data reporting from missions, service delivery module of ERP, etc.
- Review and proffer solutions to LSD director regarding medical aspects of Board of Inquiry recommendations

E. Procurement
- Develop technical specifications and statement of requirement (SOR) for medical equipment, consumables, drugs and pharmaceuticals, blood and blood products
- Develop SORs for commercial medical services
- Management of UNHQ global contract for medical services
- Oversight role in local procurement activities

F. Training

- Medical personnel in medical planning and management of medical resources
- Chief medical officers annual workshop

Source: MSS' response to the Inspector's questionnaire.

Annex V

Overview of action to be taken by participating organizations on JIU recommendations
JIU/REP/2011/1

Report		Intended impact	United Nations, funds and programmes												Specialized agencies and IAEA												
			United Nations*	UNCTAD	UNODC/UNOV	UNEP	UN-HABITAT	UNHCR	UNRWA	UNDP	UNFPA	UNICEF	WFP	(OTHERS)	ILO	FAO	UNESCO	ICAO	WHO	UPU	ITU	WMO	IMO	WIPO	UNIDO	UNWTO	IAEA
	For action		☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☒	☐	☒	☒	☐	☒	☒	☒	☒	☒	☒	☒	☒
	For information		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☑	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐
Recommendation 1		g	E	E	E	E	E	E	E	E	E	E	E		E		E	E		E	E	E		E	E	E	E
Recommendation 2		g	L	L	L	L	L	L	L	L	L	L	L		L		L	L		L	L	L		L	L	L	L
Recommendation 3		b	E		E	E	E	E	E						E		E	E		E			E		E	E	E
Recommendation 4		a	E							E																	
Recommendation 5		e	E																								
Recommendation 6		d	E																								
Recommendation 7		c	L																								

Legend: **L** : Recommendation for decision by legislative organ
☐ : Recommendation does not require action by this organization
E: Recommendation for action by executive head

Intended impact: **a:** enhanced accountability **b:** dissemination of best practices **c:** enhanced coordination/cooperation **d:** enhanced controls and compliance
e: enhanced effectiveness **f:** significant financial savings **g:** enhanced efficiency **o:** other

* Covers all entities listed in ST/SGB/2002/11 other than UNCTAD, UNODC, UNEP, UN-HABITAT, UNHCR and UNRWA